WEST VIRGINIA I/DD WAIVER
REQUEST TO CONTINUE SERVICES

Submit by fax to (866) 521-6882 or email to wviddwaiver@apshealthcare.com

Date Submitted:			
Provider Agency:		Agency Location (if applicable):	
Name of person submitting request:			
Phone #/Extension:		Email Address:	
Member Name:		APS ID:	
Anchor Date:			

Type of Request (complete only applicable section[s]):

☐ Eligibility extension request	Anticipated dates of extension:	From:	
		To:	
Respite Crisis Site Admissions ☐ Respite: Crisis Site initial admission ☐ Respite: Crisis Site extension admission	Anticipated dates of admission:	From:	
		To:	
☐ Exception to SC monthly home visit requirement (Next home visit should take place early in the following month; I/DD-12 with approval must be placed in member file in lieu of I/DD-3)		Date of last home visit:	
☐ Exception to SC bi-monthly day visit requirement (Next day visit should take place the next month—for example, if request for exception to Feb visit is approved, the next visit will take place in Mar and the visit after that will occur in May)		Date of last day visit:	
Exception to Interdisciplinary Team (IPP) requirements: ☐ Exception to hold meeting without member or legal representative present ☐ Exception to hold meeting outside mandated timelines		Date of last annual IPP:	
		Date of last 6-month IPP:	
		Date IDT meeting is expected to be held:	

Briefly describe the reason for the special request:

***Provider should include this form with the member's clinical record for verification of any approvals**

*ASO staff should include summary of approval in CareConnection® in member's record

☐ Approved	Date Expires (extension only):	
☐ Not Approved		
☐ Requested Additional Documentation (see notes section for more information)		

Notes:

Name of ASO staff reviewing request: _____

Email Address: _____